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St. Bartholomew's Hospital Journal,

JANUARY 14th, 1899.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

NO Bart.'s man can have been unmoved by the news of Professor Kanthack's death. Those who only knew of his achievements and reputation must have deplored the brilliant scientist, but those who came under his personal influence have in addition to mourn for one of exceptional force and attraction, a staunch friend. To all of them the news came with a deep sense of cruel loss. He has held so unique a position in the regard of all that it is only fitting that the JOURNAL of the Hospital, to whose fame he so conspicuously added, should attempt, in however inadequate a manner, to give expression to that sense of bereavement.

Alfredo Antunes Kanthack was born at Bahia in Brazil, on March 4th, 1863. He was the second son of Emilio Kanthack, who was at one time British Consul at Para in that country. He came to Europe in 1869, and went to school in Germany from 1871 to 1881. In this latter year he came to England, spending a few months at school in Liverpool. His school life gave little indication of the brilliant career which was to be. His intellectual powers were late in developing, though they subsequently matured rapidly.

His college life began in 1882, when he entered University College, Liverpool. He graduated B.A. at London in 1884, took the intermediate M.B. the next year, and the final B.Sc. in 1886, passing with honours on each occasion. In 1887 he became a student at this Hospital, and secured the diplomas of M.R.C.S. and L.R.C.P. In the following year he passed the final F.R.C.S. examination, and graduated M.B. and B.S. at London with honours in every subject, and the gold medal for obstetrics. Remembering his stern denunciation of the examination system in vogue in this country, it is interesting to recall how complete was his success in a department to which he attached so little importance.

It was when he went to Berlin in 1889 that he showed that his power of observing facts for himself was in no whit inferior to his power of acquiring the facts observed by others. Working under Virchow, Koch, and Krause, he speedily won a position for himself in the world of research. His admiration for Virchow was so well known, that we may quote from the *British Medical Journal* for December 31st, 1898, Professor Virchow's tribute to his memory. "I am deeply distressed to hear of the sudden death of my faithful friend Kanthack, whom I so recently saw when I was in England. I now bid him a last farewell. May English medicine never lack such men."

In 1890 he came on the junior staff of this Hospital as Midwifery Assistant under the late Dr. Matthews Duncan, in which capacity he won more golden opinions. It is a striking testimony to the position he already held in the scientific world that while still a member of the junior staff he was appointed one of the Commissioners to investigate

leprosy in India, its pathology and treatment. The Commission was elected jointly by the Royal College of Physicians, the Royal College of Surgeons, and the Executive Committee of the National Leprosy Fund.

His association with Cambridge dates from 1891; he went there on his return from India, as John Lucas Walker student. He became a Fellow Commoner of St. John's College, a foundation which has adopted the enlightened policy of preserving this distinction for the purpose of attracting such men within its walls rather than those for whom the grade was originally intended. Besides playing an important part in organising bacteriological work in the pathological laboratory, he devoted himself with zest to research work once more. Here began his important observations on the cells of the blood with relation to the problems of immunity. He also published a paper on Mycetoma, proving its close relation with actinomycosis.

In 1892 he returned to Liverpool, intending to practise as a physician. He took the M.D. of London and the M.R.C.P. He became Medical Tutor at the Royal Infirmary, and Demonstrator of Bacteriology in the Medical School. But his stay here was brief, and an opportunity more commensurate with his abilities was opened to him by the offer of the Lectureship in Pathology at this Hospital. The pathological department at once underwent a rapid development, and was consolidated by his further appointment as Lecturer in Bacteriology, Pathologist to the Hospital, and Curator of the Museum. Clinical pathology, a branch of the subject in which he was specially interested, was systematically studied in a way which, however far it fell short of his ideal, probably surpassed its practice at any other hospital or college in this country. He at once attracted the younger men to the subject, his classes were largely attended, and he evoked in them a spirit of research previously unknown. Enormous as were the labours thus involved, he still found time to pursue his researches. It was during this period that he published jointly with Mr. W. B. Hardy the important papers on Wandering Cells which aroused so much attention, the chief of which appeared in the 'Philosophical Transactions of the Royal Society.' To accomplish this, hurried journeys between London and Cambridge were necessary. The strain was too great, and he became an easy prey to typhoid fever during the summer of 1894. During his severe attack of this disease he was warded in Mark under Dr. Church. On his recovery he again threw himself most energetically into the life of the Hospital and the ever-growing work of his department. It was soon found necessary to assist him by the appointment of a demonstrator and two assistant demonstrators of pathology.

The continued illness of Professor Roy rendered the appointment of a deputy necessary at Cambridge in 1896. It was only natural that the university should turn to Dr. Kanthack; for a time he fulfilled the duties both at Bart.'s and Cambridge, but early in the next year he gave up his appointments here to reside in Cambridge. He was given the degree of M.A., *honoris causâ*, in the University, and was elected a Fellow of King's College and an F.R.C.P.

On the death of Professor Roy in the autumn of 1897 Dr. Kanthack's appointment as his successor was justly regarded as a certainty. It was now felt that he had a position worthy of him, and that he had the opportunity of developing that school of pathology which was a cherished ambition. But it was not to be. The work of organising the department had just been satisfactorily accomplished, students and those interested in research had gathered round him, when his health began to fail. He took a holiday, and returned to work in October. Very shortly, however, he became jaundiced, and had a severe attack of abdominal pain. The diagnosis was not long left in doubt. An abdominal tumour was detected, and it clearly was of a malignant nature. He rapidly became worse, and died on December 21st. The funeral service was held in King's College Chapel on Christmas Eve. No more impressive surroundings could be imagined for the last tributes to one of such brilliant achievement and promise, now untimely dead. The representative gathering on that occasion was but another indication of his place in the affection and esteem of all who knew him. Among the numerous wreaths were those from the Staff and Medical School of St. Bartholomew's Hospital. The interment took place at the Histon Road Cemetery. He leaves a widow, to whom the sympathies of all will go out.

This is not the time or place to attempt an estimate of his position in the scientific world. The sense of personal loss must be, for all of us, still too strong. But when that time comes we know that, short as his career has been, he will hold distinguished rank in the opinion of those best fitted to judge. Yet we must all feel that all he accomplished was but a fragment of what he could have done had not the amount of routine work and organisation which fell to his lot been so enormous. It was his fate that wherever he went he had all the labour of organisation, and very little of the gratification from the results thereof. Liverpool, Bart.'s, Cambridge, at each it was the same story. The list of his writings, which we publish, gives some idea of his untiring activity, but it gives no adequate conception of his stimulating influence on all around him. Says the writer in the *British Medical Journal*, "He seemed able to get work creditable to both master and pupil out of the most unpromising material." He certainly developed an enthusiasm for pathology in the most unexpected quarters. One of our correspondents says very truly that we "have lost a personal friend, who was never too busy to give advice, who knew exactly the needs of

each, and who endeavoured to help them to the utmost extent of his power." All who have had occasion can confirm the literal accuracy of this description. Cosmopolitan in his training, wide in his interests, thorough in all that he did, we had trusted that he would raise up a great school of pathology in England. He meant to do it, and he would have done it. He will have successors, but who can fill his place? The loss is irreparable.

His public utterances marked him as an uncompromising reformer. From the chair of the Eighth Decennial Contemporary Club he spoke in no measured terms of the defects of the present system of medical education, and he returned to the attack in his Mid-Sessional Address before the Abernethian Society on "The Science and Art of Medicine." All reformers tend to be rather one-sided in the presentation of their case, but no one can deny the cogency of his arguments.

The JOURNAL of the Amalgamated Clubs must not lose sight of the keen interest he displayed in the welfare of students, whether in sports or work. The President of the Abernethian Society has already publicly referred in eloquent terms to the prominent part he played in work of that society. This JOURNAL has lost one of its ablest and most ready contributors, and we do not forget that the very last article from his pen appeared in these pages. In every department his death causes a terrible gap.

It was a full life that he crowded into thirty-five short years. Ever unsparing of himself, he knew how to "scorn delights and live laborious days."

> "But the fair guerdon when we hope to find
> * * * * * *
> Comes the blind Fury with the abhorrèd shears,
> And slits the thin-spun life."

Great though his achievements, in his grave are buried yet fairer hopes. But not in vain did he labour. He lives still in the enthusiasms he has kindled.

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Compiled by CHARLES R. HEWITT, Assistant in Library, Royal College of Surgeons.

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THE Lumleian Lectures before the Royal College of Physicians will be delivered by Dr. Gee, on March 16th, 21st, and 23rd, at 5 p.m. The first lecture will be on the Causes and Forms of Bronchitis; the second on the Nature of Pulmonary Emphysema; and the third on the Nature of Asthma.

Dressers and Dressing.

Being the Mid-Sessional Address to the Abernethian Society, delivered on January 12th, 1899,

By JAMES BERRY, F.R.C.S.

MR. BERRY began by paying a tribute to the memory of his lamented friend Dr. Kanthack, and then said:

When your Committee paid me the compliment of asking me to deliver this Mid-Sessional Address I had to consider what subject I should choose. I looked through a list of the addresses that had been given by previous speakers on similar occasions, and was somewhat appalled by the learned and elaborate nature of the discourses that had been delivered. It seemed to me, however, that I might perhaps interest and amuse you if I chose some topic which could be dealt with in a somewhat lighter manner. It struck me then that there was one subject of which I had had at least a good deal of experience, and I chose "Dressers and Dressing."

Now this subject might be dealt with in various ways. I might deal with it, for example, historically, and speak of the origin of dressers, and their gradual evolution from the "cubs" of the last century—an inelegant term for dressers which I am sure that few would now consider appropriate. I propose, however, simply to speak to you of dressers as I know them and have known them, and to tell you a few stories about some of them.

Now a detailed classification of dressers seems to me difficult and unnecessary. I will merely divide them into two main classes, the perfect dressers—shall I say the large class of perfect dressers?—and the imperfect dressers; and we will hope that, in this Hospital at least, the latter class is a very small one.

The perfect dresser—how shall I describe him? Well, he is never late in the surgery or elsewhere. He does all the work that he has to do energetically and enthusiastically, and to the best of his ability. He takes every opportunity of seeing as much surgery as he can, and he endeavours, by reading up his cases, to understand them thoroughly. He never fails to write notes of his cases at the proper time, and he always writes good notes. He does not leave the Registrar's blue flags unattended to for more than, let us say, two or three days at the most. He does not forget to describe the pathological appearance of tumours or other morbid products that have been removed by operation, nor to make a note of the patient's condition upon his discharge from the hospital. He does not omit to copy out his post-mortem notes.

A perfect dresser also, when helping at an operation, does not drag ligatures over the edge of a bowl; nor does he, after he has carefully sterilised his hands, take off outside dressings or remove blankets, and then without further preparation of his hands proceed to help at an aseptic operation. He is kind and gentle to the patients. Perhaps some of my friends on the right (the sisters) would like me to add that a perfect dresser does not in bad weather enter a ward and leave his wet umbrella to drip on a polished floor—shall we say in Lawrence? Nor does he go into a ward to take notes on a case just at dinner-time—shall we say in Henry?

Such are some of the characteristics of the perfect dresser, but I need say no more; he is, of course, well known to all of us, and if I were asked to show examples of the perfect dresser I would merely reply—look around you in this theatre.

I come now to the small and doubtless insignificant class of imperfect dressers with whom we are naturally not so familiar. And here I feel that I am on somewhat delicate ground. Perhaps it is just as well for me that I am no longer your surgical registrar, and shall not have to-morrow to encounter a crowd of indignant dressers, some of whose imperfections I now propose to describe. But lest anyone should feel anxious, let me say at once that in speaking of certain dressers I do not propose to mention their names. Nor do I propose to mention all the varieties of imperfect dresser with which I am acquainted. I shall merely allude to a few types that seem to me to justify the term imperfect, and to tell you a few stories about them.

I will begin with the pedantic or bumptious dresser. He is usually a very superior person, he knows more than any of the other dressers—or thinks he does; he certainly knows more than the house surgeon, more at any rate than the junior house surgeon, and he is anxious to show off the knowledge that he possesses. It is this kind of dresser who in the evening looks up some abstruse point in

surgery, and then next day innocently asks some question about it of his surgeon or house surgeon, apparently for the sake of obtaining information, but really to display his very superior knowledge of the subject. A minor form of pedantry is often met with in the case of dressers who persist in writing the word chloroform with the symbol $CHCl_3$. It may be said, doubtless, that there is in this case an abbreviation, and so a saving of the dresser's valuable time; but this is so slight that I am uncharitable enough to believe that the real reason is to display the dresser's knowledge of organic chemistry. Certainly a saving of time cannot be urged when ether is written $(C_2H_5)_2O$, as I have often seen it in the ward notes, and I remember on at least one occasion seeing the abbreviation CON_2H_4 used in place of the exceedingly long word "urea."

Then there is the *timid dresser*, who is so afraid of doing wrong, that he is apt to leave undone that which he certainly ought to have done. A certain house surgeon and his dresser were on duty one evening, and were sitting together in the former's room, when up came the box carrier to say that a man had just come into the surgery with a wound of the arm. The dresser went down to attend to it, and the house surgeon followed a few minutes later. What the latter then saw was this:—At the further end of the room the dresser was taking out a tooth from another patient or tying up a finger, or attending to some such trivial case. Seated on the chair by the door was the man with the wounded arm; across the wrist was a deep cut, which had severed the ulnar artery, and this was spouting away vigorously. The dresser, who was of a careful and cleanly disposition, not liking to see a mess on the floor, had placed there a large surgery bowl to catch the blood as it fell. "What on earth are you doing over there?" said the house surgeon, catching hold of the patient's arm, and immediately putting his thumb on the bleeding artery. "Why didn't you attend to this case first? Don't you see that the man is bleeding seriously?" "Oh yes," said the dresser, "but I thought that that case was too serious for me to attend to, and that I had better leave it for you!"

Sometimes the timidity of a dresser takes a more extreme form. A certain dresser was sent for to the surgery, and found a man with a dislocation of the jaw. The dresser was examining it, when the bone suddenly slipped back into its proper place. (I suppose it had only been partially dislocated.) The dresser was much frightened, and feared the wrath of the house surgeon for having reduced the dislocation without sending for him; so he thought that his best plan would be to try to reproduce the dislocation, and then say nothing about his having reduced it. He was busily engaged in this attempt when he was surprised by the house surgeon, to whom he promptly confessed what he had done.

Talking of the lower jaw reminds me of another type of dresser—the *rash dresser*, who is only too ready to undertake treatment that he had much better have left to the house surgeon. The rash dresser often affords an illustration of the saying that a little knowledge is a dangerous thing.

A late house surgeon once told a dresser to open a certain abscess of the front of the thigh; the dresser, of the bold type, took a knife and promptly drove it straight into the thigh—to a depth of about four inches the house surgeon told me, but I think he must have exaggerated a little. The house surgeon, who knew where the femoral artery was, expected to be called upon to treat a punctured wound of that vessel, but fortunately no harm resulted; the dresser had just missed the artery.

Many years ago there lived near the Hospital a man who had had the misfortune to dislocate his lower jaw; the dislocation was reduced. Now I suppose I need hardly tell any one here that a jaw-bone that has once been dislocated is not unlikely to become dislocated again; and so it was with this poor man. His jaw frequently became dislocated, and as he was unable to reduce it himself he was in the habit of coming to the Hospital to have the bone put back into its place. Perhaps I ought to explain for the benefit of some of those present that when the jaw is dislocated the mouth remains wide open, and the patient is unable to speak. Now on one occasion this man came to the Hospital, as he had so often done before, with his mouth wide open, and pointing to it with his finger to explain that he wanted the dislocation reduced. He was received by the dresser on duty, who had probably never heard of a dislocated jaw, much less seen one. However, he looked at the man's mouth, and rapidly making a diagnosis, said to the patient, "Ah! I see what is the matter with you. I will soon relieve you of that. Sit down in that chair." He went to the other end of the room, procured the necessary implement, returned to the patient, and before the unfortunate man could realise what was happening the dresser had extracted a decayed molar which he had noticed there. I believe that the language which ensued was scarcely fit for publication.

The following story dates from the time when I was myself a house surgeon, and illustrates the fondness that some dressers have for the use of styptics. One evening when I was on duty I was busy putting up a fracture in the back ward of Rahere (Rahere in those days was a surgical, not a medical ward), when old Clark the box carrier arrived to say that there was a man in the surgery who had received an injury to the face, and who was bleeding from the mouth. I dispatched the dresser to the surgery, and followed a few minutes later when I had put up the fracture on which I was engaged. I shall never forget the sight that met my eyes when I reached the surgery. Seated in the surgery arm-chair was the unfortunate patient, his face all smeared with blood. Arranged around him on stools or on the floor were some half-dozen of the surgery bowls partly filled with blood and perchloride of iron, and mess generally. In the midst of them stood the dresser armed with a large brass syringe, busily engaged in squirting perchloride of iron into the patient's mouth. You can imagine what a horrible state the man's mouth and teeth were in. And when I came to look for the source of hæmorrhage, which after all was but trivial, I found that the man had broken his lower jaw, and that the bleeding was merely from the broken ends of the bone. It stopped directly the fragments were pressed into apposition.

A dresser once watched a hydrocele being tapped, and was much interested; in the afternoon he was on duty in the surgery when in came a man with—as the dresser thought—a similar swelling; he thought that the operation of tapping was such an easy one that it would be unnecessary to send for the house surgeon; so he made all preparations to do the operation himself, and was about to plunge a trocar into the swelling when one of the residents happened to pass by, and seeing what was going on, told the dresser to desist, as the case was not one of hydrocele at all, but of œdema of the scrotum and general dropsy.

There is also the *ignorant dresser*, the dresser who knows nothing, and who is fully aware that he knows nothing. Now I confess that I have a great liking for this class of dresser—the honest, ignorant dresser; after all we were all ignorant dressers ourselves at one time or another, and I suppose it is a feeling of sympathy which makes me like these dressers. Another reason why I like the ignorant dresser is that he is good raw material for teaching; the less he knows the more one is able to teach him. But here I must differentiate between the ignorant dresser who is anxious to learn, and the ignorant dresser who is not anxious to learn. It is of the former that I am speaking; for the latter I have no respect at all.

A dresser was once helping a house surgeon to tap a hydrocele, an operation which was quite new to him, and as he watched the clear yellow hydrocele fluid running away he turned to the house surgeon and said, "If you please, Mr. So-and-so, would you mind explaining to me *how the urine got there?*"

Lastly, I would mention the *thoughtless* and the *cruel* dresser, and with regard to the latter I may as well say at once that this is an exceedingly rare variety. In all my experience I have never met with more than one or two to whom this term might fairly be applied. Dressers often give much needless pain to their patients, but they do so thoughtlessly and unintentionally. The following illustrates the *thoughtless dresser*. A patient came to have a tooth out; the dresser, who had been instructed how to take out a tooth, put on the forceps, carefully pressed the blades firmly down, and then began rocking them about from side to side while the patient howled; then turning to the house surgeon, said, "Would you mind coming to see if these forceps are on properly?"

There is one kind of dresser that I have not mentioned, that belongs exclusively neither to the category of perfect nor to that of imperfect dressers, or rather belongs to both of them,—a kind of dresser of whom I have had, I suppose, more experience than anyone else in this hospital (except, in a sense, Dr. West). I mean the *lady dresser*.

A question that I am often asked is, what sort of dressers do the ladies at the Royal Free Hospital make? I am bound to say, after ten years' experience of them, that there is no essential difference between men and women as dressers. The women as a whole are perhaps rather more keen and enthusiastic over their work.

In one respect I am afraid I must give the palm to the ladies; they write more voluminous notes on their cases than do the dressers of the opposite sex. It is no uncommon occurrence for me to have to listen to half a page of notes about the family history of a case of, say, a broken leg or an abscess of the neck, and the most minute details of the past history do not escape their recording pens. They have, however, their little peculiarities. I doubt whether anyone but a Royal Free Hospital dresser would have done what one of my dressers there once did. She was a new dresser, and was going

round the wards with me, I think for the first time. She had a new case, and proceeded to read out her notes. I very soon stopped and corrected her; she went on a little further, and I then stopped her again and asked her some question that she could not answer; this happened three or four times, and I am afraid I teased her rather unmercifully with my questions. Probably my dressers at the Royal Free Hospital would tell you that I tease them a good deal. Well, perhaps I do; I think it is good for them to be teased about their cases; they remember them better. Well, this particular dresser at last could stand it no longer, so she laid the notes down on the bed, stepped back a foot or two, folded her arms and glared at me! I wondered what was going to happen next, and feared there was going to be a scene; however, I soothed her down somewhat, and she finished her notes. I believe the truth is that she was really exceedingly nervous and frightened at the ordeal through which she was being made to pass in the presence of her fellow-students; I am glad to be able to add that she subsequently became a most excellent dresser.

Much might be said on the subject of note-taking. As, however, on a recent occasion in this theatre I spoke to you at some length on the subject of note-taking, and gave several examples of curious notes, I shall not say much more about notes to-night. I should like, however, to read to you some notes which probably many of you have not heard, and which illustrate the curious way in which a dresser will sometimes in taking notes lose all sense of proportion. He is apt to omit the important points of a case, or to envelop them in an overwhelming mass of unnecessary and mostly irrelevant detail. These notes some of you have probably seen already, as they were published a few years ago in the HOSPITAL JOURNAL by one of the house surgeons, who discovered them in his wards, and thought they ought to be put on record. These are the notes:

C. W. æt. 53 was admitted into — Ward on 2nd Nov. under the care of Mr. —. She is a widow for 20 years and has four children. She has a Pott's fracture of left leg.

History The fracture occurred on Nov. 2nd and was caused by falling down stairs. It was very painful when admitted; she could not stand on her foot. Had rheumatism and swelling of joints, being treated at this hospital for it. Also been subject to fits for 10 years. Has had spots on her face for about six weeks before this accident. Fissure in bowels after childbirth, underwent operation scarlet fever when about 12.

Family history. Father had rheumatism. Mother had fits Father also had sciatica Eldest daughter had fits; is dead. Father and mother both consumptive. Father died of chest disease. Mother died in a fit.

Condition on admission Rather collapsed. Appetite always bad, bowels always regular. Pain in pit of stomach. Had injury to chest about 3 weeks ago. Complains of pain in side, when she tries to rise, referable to injury of chest.

Patient is suffering from Pott's fracture.

Nov. 11th. Rheumatism bad, not much sleep ankle bad. Appetite bad. Tongue furred. Leg pains. It is up in suspensory splint.

Temp. 97·8 going down.

17. The leg was dressed yesterday Still a little painful. Patient complains of very little pain

24. The leg was put in plaister yesterday. House surgeon says it's getting on wonderfully well Slept last night for a few hours, most sleep she has had right off. Appetite never very good.

Bowels have been tolerably regular but have not been open now for nearly three days.

Temp. below normal. Patient does some sewing. Urine normal

Mistakes in grammar are not very uncommon in dressers' notes. There was once a house surgeon who rejoiced in the possession of a round, jolly, somewhat red face, and hair that he would probably have described by the term auburn. One of his dressers proceeded to read out an account of a suppurating wound in these terms:—"The wound was dressed by the house surgeon looking very red and angry."

There was once a dresser who gravely recorded in his notes that "Mr. Willett, under the influence of an anæsthetic, proceeded to perform an osteotomy." Now we all have the highest opinion of Mr. Willett's skill as an osteotomist, but I doubt whether, under the circumstances mentioned, even he would have been able to do the operation with benefit to the patient.

I have mentioned, when speaking of the pedantic dresser, that dressers sometimes have an exalted opinion of their own knowledge, but the respect which they show to themselves is but slight when compared with the respect that is usually paid to them by the patients. To the patients the dresser is always *the doctor*, and he is usually treated by them with the greatest respect and deference. I cannot refrain from telling you a little story *apropos* of this. One of the surgeons of this hospital was going round his wards one afternoon with a dozen or so of students. A certain case had just come in. The surgeon described the chief points of the case to the students, and laid some stress upon some one symptom which was a little peculiar. Then he turned to the first student and said, "Now, So-and-so, you have heard all about this case, what do you say? Would you recommend that any operation be done upon it?" The student, who did not know in the least whether it was a suitable case for operation or not, but thought that he ought to say something, answered boldly "No." The surgeon then turned to the next student and asked his opinion. This individual, also not knowing what answer to give, but evidently thinking that the first man was a good lead, also said "No." Then the question went all round the class, and everybody agreed with the first two. "Well," said the surgeon, "you are all wrong, for I am going to operate." "No, you ain't," said a voice from the bed; "'ere's fifteen doctors say it ain't a case for operation, and I ain't goin' to let you operate on me!" And the patient got up and went out of the hospital. History relates that a few weeks later he was discovered in another ward, having re-entered the hospital to have the operation done after all.

And now, ladies and gentlemen, I see that I have already taken up so much of the time allotted to me that I must bring my anecdotes to an end.

[In conclusion, Mr. Berry offered a few words of advice as to the mode in which he thought that dressers could perform their duties with most advantage to themselves, and recommended them above all to cultivate habits of observation, to take every opportunity of seeing as many cases as possible, and to endeavour *during their dresserships* to learn as much as possible about each case both by reading and by frequent visits to the museum.]

Some Rectal Diseases.

By F. C. WALLIS, M.B., F.R.C.S., Surgeon to the Metropolitan Hospital and Assistant Surgeon to Charing Cross and St. Mark's Hospitals.

V. THE TREATMENT OF FISTULÆ.

A FISTULA is a sinus, discharging pus, the surface of which is lined with granulation tissue; around this is a varying amount of fibrous tissue, the amount depending upon the length of existence of the fistula. But, unlike sinuses in other parts, a fistula, owing to its position, to the constant action of the surrounding muscles, and the possible fæcal infection, is never allowed to remain at rest for any length of time, and consequently rarely heals without some operative help.

To say that no case of fistula gets well without an operation would be incorrect, and probably most surgeons have had experience of cases of undoubted fistula which have healed after the introduction of a probe, or some such mild counter-irritant has been used. But these are rare exceptions, and must not be taken into consideration when the question of treatment arises.

Palliative treatment in these cases is most unsatisfactory, and I had almost written unsurgical. But the idiosyncrasies of patients occasionally necessitate that some measure or other short of a "cutting operation" shall be resorted to.

Success has followed when the external opening of the fistula has been dilated by a tent, and the track swabbed out with strong carbolic acid, iodine, or some other strong irritant. Solid nitrate of silver has been placed in the

sinus, and left there for some minutes, and then removed, or the sinus has been rubbed with solid copper sulphate.

Again, there is the treatment by an elastic ligature. This is introduced by a special instrument into the sinus, and then the end brought out through the bowel; both ends are clamped tight by a pewter clip, and the ligature gradually cuts its way out, thus performing in about a fortnight what is done with a knife in less than three seconds.

Such methods as the above are of course never resorted to unless there is some special reason. The best chance of success will be where the fistula is a recent one, and where there is only the one straight track.

When the fistula is of long standing, and is surrounded by a quantity of fibrous tissue, or when secondary sinuses lead off from the main one, any such treatment as suggested above is worse than useless.

Moreover, when any such palliative measure as the above is tried, it is as well that it should be under protest as far as the medical man is concerned, and no promise of a cure should be made.

Operations on fistula in ano vary from a simple straight incision to an operation of some magnitude, according to the nature of the fistula.

During the last eighteen months at St. Mark's Hospital I have in all suitable cases of simple complete fistula, after injecting some 4 per cent. solution of eucaine, operated in the out-patient department, the patient returning home afterwards. This has been done now a number of times, and the cases have all done well.

It is necessary in these cases to be somewhat careful in choosing the patient. He must be possessed of reasonable intelligence, and have some ideas as to cleanliness.

The patient is placed in the knee-elbow position, and after the eucaine injection a probe-pointed fistula director is passed into the external opening, and the finger in the rectum guides the point of the director to the internal opening. The director is passed through this, and then the handle of the director is depressed or elevated, as the case may be, until the point can be pushed out into the open, so that the whole length of the proposed incision is in view. A curved sharp-pointed bistoury is now passed along the groove of the director, and the whole track of the fistula is laid open.

The buttocks are kept widely separated, and the track carefully examined; any excessive fibrous tissue is removed, and overhanging edges are pared away. The incision is plugged rather firmly with cotton wool saturated with 1—500 perchloride. A good pad of wool and a firmly tied T-bandage complete the dressing. A printed slip of paper giving accurate instructions is handed to the patient, and he returns on the third or fourth day to be seen again at the hospital.

I was first induced to try the above plan because of the large number of cases which are always waiting for admission at St. Mark's Hospital. It was rather in fear and trembling that the first cases were undertaken, but the success has been so pronounced that I have thought it worth while to dwell on some of the details.

Whatever class of society a patient comes from, it may be that he is so circumstanced as to be unable to lie up for any length of time, and the above treatment is available in a certain number of such cases.

In the ordinary way a patient should have the bowels well acted upon some two days before, and an enema should be given on the morning of the operation. At the time of the operation, after general anæsthesia has been produced, the patient is placed *on the same side as the fistula*, and the upper buttock is held well apart by the assistant.

A director is passed into the external opening, and the finger in the bowel directs the probe to the internal opening; if this cannot be found, the point of the director should be pushed through the thinnest part of the mucous membrane, and then brought outside the bowel. The track is then laid open, all granulations are scraped away, and diligent search is made for any other sinuses which may burrow off from the main one. The existence of these is generally shown by small areas of deep-lying granulation tissue remaining after the main track has been scraped clean. A probe passed along these will indicate their direction and depth. These secondary sinuses should be in nearly every case laid freely open, otherwise the fistula is apt to recur. The exception to this rule is when a sinus runs parallel to the bowel, and extends well beyond the internal sphincter.

In such cases it is advisable to try everything short of laying the sinus open into the bowel, because of the possibility of fæcal incontinence as a permanent result.

As far as my own experience goes, I have so far avoided laying open such a sinus when secondary to the main fistula. Scraping away granulations, and careful plugging afterwards, has in the end been rewarded by the sinus being covered in by granulations.

Why not do this with any secondary sinus? it may reasonably be asked. The answer is that the one way is sure, and there is no risk; the other is not sure, and there is a chance of its not being successful. Moreover the length of time that this latter method takes is a serious consideration.

In more than 95 per cent. of cases of fistula the internal opening will be found between the sphincters, or at all events below the *internal* one. As long as the external sphincter alone is divided, and in one place only, there is no reason to fear that fæcal incontinence will take place. If, however, there are two internal openings—a rare occurrence,—and the sphincter at the time of operation is divided in two places, permanent weakening may follow. When the *internal* sphincter is divided temporary incontinence always occurs; but if the incision goes straight through the fibres of the muscle, by the time the wound has healed the

power of the sphincter should have returned. If, however, the incision divides the muscle obliquely, it is likely that permanent incontinence may result in a greater or lesser degree.

It is difficult to imagine a more distressing condition than this one of fæcal incontinence, and any one who has seen a patient suffering in this way will not hesitate to agree that everything should be attempted before the risk of this possibility is run.

Internal fistulæ are made complete by an incision from without into the abscess cavity when it exists, and from this a director is passed down the sinus through the internal opening, and the remaining tissues divided in the manner described above.

If there is no definite collection of pus, a director with a bent probe-pointed end is passed into the internal opening, and the operator cuts down on the point, which is then pushed through, the operation being finished in the usual way.

Attempts have been made from time to time to get immediate union in cases of fistula, and some authors tell of a certain amount of success when this has been done.

My own experience is limited to three cases, the first of which was a failure, but the remaining two were so successful that I fully intend doing the operation more frequently in certain picked cases.

The fistula must consist of the one main track only if the operation is to meet with any success.

The following is a brief description of the operation which I performed in two of the cases mentioned above:—The patient being in the *lithotomy position*, the director is passed right through, and the point brought outside the anus in the usual manner. The internal opening is now incised for about half an inch outwards along the line of the director, and the director is pressed up against the end of the incision, thus placing the incision *behind* the director. This incision is now carefully sewn up with horsehair behind the director, and the process again repeated until all the incision inside the bowel is sewn up; the rest of the tissues are then divided, any fibrous track is cut away, *deep* kangaroo tendon sutures are passed across the floor of the fistula, and horsehair unites the skin edges. The whole length of the incision is painted with Whitehead's varnish, and dressed with some gauze and wool.

The bowels are confined for five or six days, and then acted on by oil enemata.

Both the cases that were successful left the hospital healed on the ninth day.

The difficulty has hitherto been to get the mucous membrane together, but if the above method is carried out this will be quite easy to accomplish. It is well worth trying; if success is attained, at least a fortnight is saved. If the attempt fails, the wound granulates up in the same time that it would take under ordinary circumstances.

Various opinions have been expressed by well-known physicians and surgeons as to the advisability of operating on phthisical patients suffering from fistula. The question is a most interesting one and also important, but it is not possible to discuss the matter in this paper.

When a patient who has obvious phthisis comes to me complaining of fistula, I always insist that a physician shall be seen; and when I know the result of his examination, I then decide what shall be done.

It is my rule to operate in most cases, except where rapid progress is being made by the disease in the lungs.

At first the external sinus only is laid open and the surrounding skin removed, the wound being packed in the ordinary way for a few days. After this the whole surface and skin edges are brushed over with *pure lactic acid* twice a week, otherwise the dressing is the same. When this external sinus has nearly healed, the track running into the bowel is laid open and treated in the same manner.

Progress is slow, but satisfactory in the end.

The patient *should not lie up* if it can be possibly avoided; and if general anæsthesia can be dispensed with, so much the better. I have carried out the above treatment in a certain number of cases in the out-patient department at St. Mark's, the incisions being made after injecting 4 per cent. eucaine. The patients have never laid up for more than a couple of days, and the results have been most satisfactory.

The after-treatment of fistula is usually quite simple. The dressings should not be disturbed until two to three days after the operation, when all plugging should be removed, the wound well washed and *lightly* plugged with cotton wool soaked in some antiseptic. This dressing and washing should be done twice in the twenty-four hours, and any fæcal soiling should be at once dealt with.

Perchloride of mercury, carbolic acid, oxydol, sanitas, any or all of these and many others are used as lotions, and it is as well to ring the changes.

A wound sometimes gets tired, so to speak, of all lotions, and then they do surprisingly well for a few days with oxide of zinc, starch, and boric powders in equal parts, dusted on dry cotton wool, and applied lightly over the wound. Nitrate of silver is occasionally of the greatest service in accelerating the healing.

Bridging is the bugbear which has to be always carefully looked for and immediately dealt with, otherwise all the trouble will recur.

Any suspicious spots of flabby granulations, or pus areas which are not easily washed off in the ordinary way, should be carefully searched with a probe for any *bridging*, and when this occurs the bridge should be broken through by the probe, or even divided with a knife if necessary, and some packing placed at the bottom.

This bridging *may* be the result of inadequate packing, but it is more often caused by a deep layer of granulations

breaking down whilst the superficial layer is maintained, thus forming a sinus.

It is most important that this bridging should be constantly looked for, especially in deep fistulæ which are granulating up rapidly. (On the other hand, they are very apt to occur in the slow-healing fistulæ of phthisical patients.) If this is from any cause overlooked the fistula will recur, a result far from satisfactory to either of the parties concerned.

The last and most difficult part to heal is the incised bowel, and until this is thoroughly sound a patient should not be considered cured.

(*To be continued.*)

Dentistry for Medical Men.

By R. C. ACKLAND, M.R.C.S.Eng., L.R.C.P., L.D.S.,
Assistant Dental Surgeon to the Hospital.

II. HINTS ON THE EXTRACTION OF TEETH.

To find the offending tooth, probe all existing cavities so as to discover if there be an irritated or exposed pulp. The direct application of a drop or two of rather hot or rather cold water into the cavities suspected will often indicate the one in which the pulp is inflamed. Gently "tap" the teeth containing the cavities to see if the peridental membrane is inflamed. If the patient has a swelled face from a tooth, proceed to find the one which caused it. Observation and gentle pressure both outside the face and within the mouth will generally be found to localise the spot at which the swelling is most on the one hand, and the tenderness is greatest on the other. This will be found to be on the gum directly covering the root which caused it. Lastly, the indication of the patient as to the cause can be taken, but no great dependence can be put on this. The pain is by him naturally associated with what he considers to be his worst tooth, whilst it may possibly be caused by another tooth, the cavity of which, by its position, has not been discovered by the tongue, &c. In hospital practice this is especially the case, and on no account should the tooth indicated by the patient as the cause of his trouble be extracted until the operator has convinced himself that it is the cause, or chief cause, of the pain.

The position of the patient will depend on the tooth to be extracted being in the upper or lower jaw. If the tooth or root is one situated in the upper jaw, the patient should be seated somewhat higher than in an ordinary chair, and reclining back sufficiently to allow of the operator having the available light direct on the upper arch. When it is a lower tooth or root which is to be extracted, the position is reversed, and the patient is kept seated low and sitting upright, so that the light falls down on the lower arch. In both positions the head of the patient should be so placed that the operator can apply the necessary force to the best advantage, and in calculating this the heights of both patient and of operator must be considered.

The choice of instrument is of very great importance. Of the various patterns in dental forceps which a surgeon-dentist may use, few but the very simple in pattern are of any real value to the general practitioner, as constant practice in their use can only render them really effective. In extracting teeth which have but one root—such as the teeth of the incisor series and canines, or the single roots of the molar series or the bicuspids, which are treated as single-rooted teeth—the ordinary root forcep is used. The blades of this instrument are the same both for the upper and lower teeth. The shape of the handles, and the angle at which these handles join the blades, determines for which series of teeth or roots it was designed. As a general rule, the more the jaws or blades of the forcep are in a line with its handles, the easier, mechanically speaking, is it to perform the extraction, provided, of course, this straightness allows of the blades being adjusted to the root or tooth to be extracted. "The straight" forcep can be used for the upper four incisors and upper canine teeth or their roots. For the bicuspids and roots of upper molars, the protruding lower jaw prevents the use of the straight forcep. To reach these and to adjust the root-shaped blades to them, the handles of this forcep require a slight bend so as to pass into position free of the lower jaw and its teeth. The roots of the third molar, and often of the second, require a forcep with a more marked curve again. This instrument is often used for the wisdom-tooth itself; for when its crown is small, its roots are generally united in one conical mass, and they can be treated as a single root. The full upper molar forcep is only used when its crown is fully formed, and it lies well in the arch. With regard to the single-rooted teeth, and single roots of the molars in the lower jaw, the blades are so joined to the handles that the forcep escapes contact with the upper teeth. One such instrument can be used to extract any of these teeth or roots. There remains now, as far as the general practitioner is concerned, but to speak of the forceps necessary for the upper molars, more especially the first and second, and the lower molars, with again the exception that the third is generally treated as a single root, depending on its development. The normal upper molar has three roots, so arranged that the forcep designed for extracting it, as a whole, has an inner or lingual blade grooved for one of its roots, and an outer or buccal blade with two grooves separated by a point. This forcep could be used on either side of the mouth, did the shape of the handles allow of the blades being adapted to opposite teeth; consequently, for the upper molars, a right and a left forceps are necessary. The lower molar forcep has both of its blades

grooved, and with a point between the grooves so arranged that, when the blades are closed to seize the tooth, the lateral aspects of its two roots are grasped simultaneously, whilst the point passes into the interval between. This instrument can be used symmetrically. The writer has tried to describe the smallest convenient set of forceps suitable for use by a medical practitioner. In all, seven pairs of forceps have been mentioned, and he considers that the general practitioner would be wiser in keeping to these simple patterns, and aim at being proficient in their use, rather than burden himself with the many special shapes which are to be obtained. When a molar tooth is very much broken down, it is better to use the root forcep applied to two of its roots in the upper, or to one of its roots in the lower jaw, because it is difficult to apply the full forcep when the walls of the tooth are very much broken down. The risk of breaking the tooth is immensely increased if the grooves, and more particularly the point between the grooves, are not in exact position. For instance, should the point which divides the grooves not pass between the roots, whether it be on the outer side of the upper molars or on either side of the lower molars, it will rest on a point of the crown or roots, at which point the full force in seizing the tooth will be spent. This will have a tendency to split rather than grip the tooth. A further result of such an accident is that the point will probably become everted, and in future use will tend to pass outside the thin edge of the alveolar plate rather than inside. The effect of this is often seen in hospital practice, where extraction with an instrument so damaged often leads to the tearing away of a strip of the alveolus with the tooth. On the other hand, the keen edge and the narrow blade of the root forcep can be guided more easily into its proper position between the gum and the root; when there it will offer much less resistance than the thicker, wider edges of the full forcep, and so with the same amount of force can be driven farther along the root surface to a safer position.

The application of the forcep, &c.—First clearly define the outline of the tooth or root to be extracted; if it be a root or a tooth with its walls very broken, allow for elasticity or inflammation, as the case may be, of the free edge of the gum if it be a root which is to be extracted; take too broad a grip rather than too narrow a one. It is better, in extracting a root, to force the blade through a little intervening layer of gum, and even alveolus, than to force the point of a blade into the top of the root. The forefinger and thumb of the operator's left hand should be used to hold back the cheek and tongue so that a clear view of the tooth can be obtained, and later they can help force the blades home on the tooth. Finally, perhaps, they can save it from slipping from between the beaks of the forcep, and perhaps getting into the larynx.

The operation of extraction.—Having obtained a firm hold on the tooth apply your force very gradually; increase it slowly so as to dislocate the tooth. Dislocation is generally more easily managed in an outward direction, but sometimes the alveolus may give more readily inwards; this is more particularly the case in the second and third lower molars, which have a much thicker buttress of bone on their outer side; and again occasional teeth in other positions are better dislocated in an inward direction because of their position in relation to the adjacent teeth. None of the movements of extraction should be jerky, and the force in dislocating the tooth should not be suddenly applied, as thereby the pain of the extraction is very much increased. In extracting a tooth great care should be given to only use the force necessary for its dislocation. Force used in excess of this only increases the risk of a fracture. A little practice will also demonstrate the importance of not hurrying too much.

Problems in Diagnosis.

UNDER this heading we hope to publish from time to time clinical notes of medical and surgical cases that offer scope for the exercise of our readers' diagnostic acumen. With this idea in view we shall divorce the clinical notes from the account of the post-mortem, or whatever sequel happens to settle the diagnosis of the case. The post-mortem notes of the following case, for instance, will be found on page 64 of this issue of the JOURNAL. We invite contributions to this column, and would suggest that it is not so much the weird and very rare disease that proves a useful problem, as a common disease that runs an atypical course and thus eludes diagnosis. We are aware that this is not an original feature of a hospital journal, for one of our contemporaries, the *St. Mary's Hospital Gazette*, has published an excellent series of such problems, but it appears to us a useful method of recording interesting cases.

David W—, æt. 44, gas foreman, was admitted to the Hospital on June 8th, suffering from pain in belly, swelling of it, and shortness of breath.

He was in usual health until May 25th, when he was seized with pain across upper part of abdomen whilst in act of stooping. The pain lasted two days, and was accompanied by much flatulence.

On May 26th patient noticed his urine to be of a red colour, due, he thought, to blood. This continued for three days only. On May 27th he was seen by a doctor, who told him his urine contained bile. Although the pain passed off, patient kept his bed by the doctor's advice. The bowels were freely open, and plenty of urine was passed. There had never been any swelling of legs or feet, and no enlargement of the abdomen had been noticed by the patient. For two or three years he had drunk alcohol freely. He had never been abroad, and denied syphilis.

On examination patient was a big heavy man, lying low in his bed, and breathing rather rapidly. There was some difficulty in sitting up in bed without first putting the feet to the ground, on account of the size of the abdomen. The cheeks showed bright red and dilated venules; no cyanosis or œdema of face. No enlarged glands or dilated veins in neck. The chest was rather barrel-shaped, but moved very fairly. Resonance was good everywhere except at right base in front, where dulness to percussion began at level of fifth rib. Air entry and breath-sounds good everywhere. The heart's impulse was not felt, but cardiac area of dulness and sounds were natural. Pulse natural. The abdomen was greatly and symmetrically distended as a whole, bulging forwards, and laterally in the flanks. The navel was moderately retracted. By contrast with the bulging forwards of the belly at the epigastrium, the sternum looked sunken. This epigastric protrusion formed the most prominent part of the whole belly, which was somewhat tense. The most resistent part, again, was the region between navel and ensiform. At the junction of these two areas of different resistance an ill-defined edge, as of the liver, was felt. A distinct fluid thrill was obtained between the two hands placed one on either side of the

epigastric swelling. The whole swelling seemed to pulsate synchronously with the heart-beat, but probably this was conducted from the aorta beneath. The percussion signs were as follows:—The region from pubes to navel, as well as both flanks, yielded good resonance. From the ensiform cartilage nearly down to the navel, and spreading laterally so as to cover an area the size of a saucer, the note was also resonant. Around the central resonant area, however, was dulness to percussion,—for a hand's breadth on either side, and for half a hand's breadth above and below. On percussing in the sitting posture the central resonant area was found to have shifted upwards, so that it only extended to halfway between ensiform and navel. Similarly, percussing with patient upon his side, the resonance merged with that present in the uppermost flank. This central resonant area was very marked; indeed, the note yielded by it deserved the name "amphoric." There was no thrill felt from flank to flank. On auscultation the swelling was dumb. The stomach-tube being passed carefully, the above conditions of resonance were not altered, nor was any change noticed when half a pint of water was passed through the tube. There was no œdema of legs or feet. Temperature on admission 100·6°. Urine sp. gr. 1020, acid, no albumen nor bile, much urates deposited.

June 15th.—Up till to-day condition has remained unchanged. Temperature rose to 101°—102° each evening, falling to normal in the morning. Thirst, dryness of mouth, and flatulence were the chief symptoms. Urine still free from bile, but contained a heavy cloud of albumen on June 9th, and always much urates. On night of 14th there was a slight rigor. At 3 p.m. to-day patient sat up suddenly in bed and cried out that he felt sharp pain in the belly. He eructated a quantity of gas and the pain passed off, leaving him, however, faint, blue, and collapsed, with cold extremities and small running pulse. He was given an ounce of brandy. At 3.40 he said he was better, there was no pain, but the general condition was still bad. At 4 he was given Tinct. Opii ♏xx, and brandy ʒss. The condition of the abdomen seemed quite unchanged. At 5.20 he complained again of severe abdominal pain, became suddenly very collapsed, and died five minutes after the onset of these graver symptoms.

Notes.

To the loss which this Hospital and the scientific world in general have sustained by the death of Professor Kanthack we have referred elsewhere. Our thanks are due to the editor of the *British Medical Journal* for his courtesy in lending the block of the excellent portrait which illustrates the article. We hope the bibliography of his writings which has been prepared by Mr. Charles Hewitt will prove a useful work of reference to our readers; it is certainly a monument to Professor Kanthack's devotion to science.

* * *

DR. WEST is to deliver the Lettsomian Lectures before the Medical Society on February 6th and 20th, and March 6th, at 8.30 p.m., the subject being "Some of the Clinical Aspects of Granular Kidney." Any Bartholomew's man will be welcome, and can obtain a syllabus on application to Mr. Sargant at the Hospital, or Mr. Hall at the Medical Society's Rooms, 11, Chandos Street, W.

* * *

ALL Bart.'s men will cordially congratulate Mr. Percy Furnivall on his appointment as Assistant Surgeon to the London Hospital; but our congratulations must be mingled with regret that it involves the loss to Bart.'s of one who has played such a prominent part in all departments of hospital life. He takes with him the good wishes of all with whom he has been associated here; and we can wish him nothing better than that he may be as successful in the future as he has been in the past.

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IN consequence of this appointment, a vacancy for a Demonstrator or an Assistant Demonstrator in Anatomy is advertised.

* * *

DR. ORMEROD has been appointed Physician to the Skin Department.

* * *

DR. SEVESTRE has been appointed Honorary Assistant Physician to the Leicester Infirmary.

* * *

DR. D. A. GRESWELL has been appointed Examiner in Therapeutics at the University of Melbourne.

* * *

DR. SINCLAIR GILLIES has been unanimously elected to the post of Assistant Physician to the Prince Alfred Hospital, Sydney, New South Wales.

* * *

LAST month we had the pleasure of chronicling the success of Bart.'s men in the M.B. Examination at the London University. We can now add that Mr. J. P. Maxwell, who gained the Gold Medal in Obstetrics, has been awarded the Gold Medal at the B.S. Examination, and that Mr. J. A. O. Briggs and Mr. Hussey obtained marks qualifying for the Gold Medal at the M.D. examination.

* * *

AT the request of the Charity Organisation Society, Dr. J. B. Hurry, of Reading, delivered a lecture at the Portman Rooms on December 7th, on "The Self-supporting Dispensary and District Nursing Association." The plan Dr. Hurry recommended is, in the main, the same as set forth in his book which was recently reviewed in these pages.

* * *

MR. W. E. SARGANT has been elected Honorary Secretary for Cases to the British Medical Benevolent Fund.

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PROBABLY the last surviving attendant at John Abernethy's lectures has passed away in the person of Mr. George Hurst, J.P., of Bedford, who recently died within a few weeks of completing ninety-nine years of life. Mr. Hurst attended one of Abernethy's lectures in 1820, and so recently as last May, seventy-eight years after hearing it, contributed an account of the lecture to this JOURNAL.

Abernethian Society.

ON Thursday, December 8th, a general meeting of the Society was held, Mr. Horder, President, in the Chair.

On the motion of Messrs. Douglas and Rawling, the President directed the secretaries to call a special general meeting for the purpose of electing a Vice-President of the Society in place of Mr. E. S. E. Hewer, who was no longer resident in London.

A case of dry embolic gangrene of the leg was shown by Mr. Weaver, and a case of probable actinomycosis of abdominal wall by Mr. Watson.

Mr. Cammidge gave an interesting address on "The Tests for Proteids in Urine," illustrated by test-tube experiments. A synopsis of Mr. Cammidge's remarks will appear in our next issue. This meeting terminated the first half of the Session.

At a special general meeting, held on December 16th, Mr. A. R. J. Douglas was elected a Vice-President of the Society.

On Thursday, January 12th, the Mid-Sessional Address was delivered by James Berry, Esq., F.R.C.S., who took for his subject "Dressers and Dressing." Mr. T. J. Horder, President, occupied the Chair, and opened the meeting with the following remarks:—"My first duty this evening is a sad one. It is to endeavour to pay an unworthy tribute to the memory of one whose irretrievable loss we have had to deplore since last we met. I refer, of course, to the late Professor Kanthack. It is not as a true friend or as a brilliant teacher that I speak of him to-night, though he was both these; it is as one of the greatest helpers and one of the ablest members of the Abernethian Society. During the past ten years the work of the Society has been very closely connected with the various lines of pathological research to which Dr. Kanthack gave his energetic attention. It was the Abernethian Society that had the honour of hearing the first results of Dr. Kanthack's work upon Tetanus, which gained the Jacksonian Prize in 1895, and also of that upon Immunity, which now finds a permanent place in *Allbutt's System of Medicine*. The many pathological demonstrations given at our 'Clinical Evenings' were too numerous to receive individual mention; they and Professor Kanthack's interest in our Society were not even interrupted by his removal to Cambridge. Finally, only as late as last July, Professor Kanthack gave this Society as its Midsummer Address that stimulating call to further activity in the branch of medicine so peculiarly his own, which received so much attention as well outside as within this Hospital. Though none of us then dreamt it would prove such, it was a strangely appropriate last word and a fitting farewell from one who was himself for ever in the van of medical progress."

Mr. Berry's address, which was much appreciated by a large audience, is printed elsewhere in the JOURNAL. Some score or so of Mr. Berry's past and present dressers from the Royal Free Hospital, who had accepted the Committee's invitation to be present, listened in rapt attention. The Nursing Staff also attended.

Christmas in the Wards.

CHRISTMAS this year was a quieter festival than is usual. Owing to the fact that Christmas Day itself was a Sunday, some of the wards decided to hold their celebration on the Saturday, and the majority on the Monday; while Tuesday and even Thursday were devoted by the remainder to their entertainments. There were the usual conjurers and ventriloquists; and the other forms of entertainment were much the same as in former years. This year, however, a new feature was introduced in the "gramophone," which was much appreciated wherever it was heard.

The ward decorations were as usual in excellent taste, and involved a good deal of trouble and forethought on the part of the sisters and nursing staff. The general opinion of unbiassed visitors assigned as usual a very high, if not the first place, to Martha; while Luke, Rahere, and John among the medical wards, and President, Charity, and Lucas among the surgical were all much admired. Last, but not least, the best thanks of a very large portion of the Hospital must be given to Mr. Valerie, who sang, accompanied by Mr. Adams on the banjo, in no less than eight or nine different wards on Monday evening; scarcely any one, we are sure, can have realised the extent of his exertions or of his good nature.

The Christmas Entertainment.

THE Christmas Entertainment given for the nurses and resident staff took place on the evenings of Thursday and Friday, the 5th and 6th of January, being preceded as usual on the 4th by a dress rehearsal, which was witnessed by those patients who were well enough to attend. The entertainment consisted of two farces and the orchestral selections.

The first piece was a well-established favourite, *No. 1 round the Corner*, setting forth the troubles and trials of two impecunious bachelors in lodgings in their efforts to "raise the wind." The parts were taken by Messrs. Farley and Hawes, who most successfully surmounted the many difficulties inseparable from a play of this character. The frequent reference to that historical personage around whom Milton wrote his poem *Paradise Lost* seemed to us rather unnecessary. Still, we suppose the words were so in the book of the play.

The second piece was a three-act farce by G. Manville Fenn, entitled *The Balloon*, and when we mention that the two principal *rôles* were taken by Messrs. Hobday and Valerie, who were ably supported by the rest of the company, further criticism is unnecessary. Mr. Valerie, in the part of Mr. Aubrey Fitz-John, had a character sketch that suited him "down to the ground," and which he developed with that inimitable spirit which we are now so well accustomed to.

Mr. Hobday, as a medical man suffering from old heart trouble with recent complications, carried the entire sympathies of his audience with him; both in the pathetic and in the more vigorous passages he was excellent. His scene with Mr. Valerie describing the escape from the balloon was perhaps the most striking success of the evening.

The female element was ably represented by Messrs. Tweedie, Slade, Ward and Morris. Mr. Tweedie, as a designing widow, betrayed a suspicious knowledge of the subject. Mr. Slade and Mr. Ward represented the youth and beauty, Mr. Slade making one of the most fetching figures we remember to have seen on these boards. Mr. Morris played the difficult part of an elderly lady with marked success.

In the minor parts Mr. Crawford, as the doctor's boy, made a decided hit; and Mr. Gibson, as the doctor's *locum*, showed early promise of a successful professional career. Mr. Whitaker, as Captain Cameron, was effective.

The orchestra played several selections during the evening, and it was difficult to believe that their practice only began with the week. The entertainment ended at the reasonable hour of 10.15, but the interval at 7.45 seemed to us at least half an hour too early.

The Rahere Lodge, No. 2546.

AN ordinary meeting of the Rahere Lodge, No. 2546, was held at the Restaurant Frascati, Oxford Street, W., on Tuesday, December 13th, 1898; the W.M. Bro. T. G. A. Burns in the Chair. A vote of condolence with the family of the late Earl of Lathom was passed unanimously, Lord Lathom having been an honorary member of the Lodge; and the resignation of Bro. Nall was accepted with regret, Bro. Nall having become a permanent resident at Yorketown, South Australia. Bros. Howard, Marshall, Heath, Burrows, and Brewerton were raised to the third degree; Bros. Coventon, Griffiths, Gay, and Tucker were passed to the second degree, and Dr. C. H. Roberts was initiated into freemasonry. The Deputy Master, for the time being, of the Sancta Maria Lodge, No. 2682, was elected unanimously an honorary member of the Lodge. A small honorarium was voted out of the Lodge funds to Bro. Sargant for assistance rendered to the Secretary, and a sum of twenty guineas was granted at the suggestion of Bro. E. C. Cripps, in aid of the Royal Benevolent College at Epsom. Bro. West was appointed to act as charity steward, and it was decided, upon the motion of Bro. Pickett, that a sum of money should be placed in his hands for the relief of those in urgent distress. The members with their guests, to the number of thirty-five, afterwards dined together.

An ordinary meeting of the Rahere Lodge was held at Frascati's Restaurant, on Tuesday, January 10th, 1899; Bro. T. G. A. Burns, W.M., in the Chair. Bro. J. A. Rigge was elected a joining member,

and Messrs. F. H. Lewis, W. W. Kennedy, and Thomas Hood having been elected members were duly initiated into freemasonry. Bro. C. H. Roberts was passed to the second degree, and Bros. Coventon, Griffiths, and Gay were raised to the third degree. A sum of twenty guineas was voted from the Lodge funds in aid of the Royal Medical Benevolent College at Epsom. The brethren and their guests to the number of thirty-eight afterwards dined together.

Annual Bart.'s Dinner in Calcutta.

THE second Dinner of the Bart.'s men in Bengal was held at the United Service Club, Calcutta, on Monday evening, December 19th, 1898, and was an unqualified success. It had been intended to have it on St. Bartholomew's Day, but the weather in August (shade temperature 90°, moisture 100 per cent.) choked everybody off. Bart.'s men form a strong contingent just now, and there was a good muster; one man "running in" three hundred miles to attend. The following were present:—Colonel T. H. Hendley, C.I.E., I.M.S., in the chair, Drs. Nield, Cook and Pettifer, Major Pilgrim, and Captains Maynard, O'Kinealy, Oldham, and Bird, I.M.S. Major Ross, Captains A. F. and C. R. Stevens, I.M.S., and Dr. Humphrey were unable to come. A telegram was received from the two latter, who dined together the same evening amid the snowy peaks of Darjiling, conveying their best wishes and toasting the alma mater.

After dinner Colonel Hendley, in proposing the toast of the evening, gave some interesting reminiscences of his student days in the sixties, when Sir William Lawrence was Surgeon, and "Tom Smith" Assistant Surgeon to the Hospital. He commented on the greater number of Bart.'s men coming out to India every year, a very different state of affairs to that existing when he entered the service. He was then, and for nearly ten years afterwards, almost the only Bart.'s man in it. Now each year brings us some more chips of the old block, and the Annual Hospital Dinner in Calcutta promises therefore to be increasingly successful. In fact the other day a medical man in Calcutta said that Bart.'s men in India had been *sporadic*, were now *epidemic*, and that he supposed they would soon become *endemic*.

Reviews.

MANUAL OF OPHTHALMIC SURGERY AND MEDICINE, by WALTER H. H. JESSOP, M.A., M.B.(Cantab.), F.R.C.S., Ophthalmic Surgeon to St. Bartholomew's Hospital. (London: J. and A. Churchill. Price 9s. 6d.)

All Bartholomew's men who have had the privilege of studying ophthalmic work under Mr. Jessop have awaited the appearance of this volume with eagerness, in the anticipation that the clearness and precision which distinguish his oral teaching would also adorn his written words. And this anticipation we think they will find amply realised, in spite of the crippling limits to which Mr. Jessop has been restricted. The first three chapters are devoted to a description of the methods of examination employed in ophthalmic work, and so far as written directions can supply the want of actual demonstration are admirable in their conciseness and completeness. The conjunctiva, cornea, sclerotic, and iris have each in turn a chapter devoted to the diseases and injuries peculiar to them. There is in the chapter on the cornea one small theoretical point on which we should venture with some diffidence to disagree with Mr. Jessop. He describes the ulceration which takes place in, *e.g.* exophthalmic goitre, as "a condition resulting from exposure of the cornea, owing to insufficient protection by the lids." But is this the whole story? There are many cases in which in debilitated subjects the corneæ are exposed by incomplete closure of the eyelids for weeks together without any ulceration, *e.g.* in the later stages of heart disease; further, we have lately seen a case of Graves' disease in which the proptosis was slight, and the corneæ completely covered during sleep, and yet ulceration of both corneæ occurred; nor in this case was the act of nictitation markedly infrequent. We feel sure that there is some further factor in the causation of this form of ulceration.

Glaucoma and cataract receive ample treatment, and there is an adequate account of the most usually accepted theories of the first of these diseases. But one of the features of the book is the elaborate account given of the operative treatment of strabismus, the minute directions given being quite sufficient to enable a careful practitioner to accomplish these small operations for himself.

An appendix contains a large number of useful formulæ, to which constant reference is made throughout the book; an account of the lenses usually employed in refraction work, and some general rules for eye operations. There is an excellent index, and the illustrations are exactly those that are required in a text-book; the only addition we should like to see being a plate showing a normal disc, and, as a contrast, an early stage of papillitis. The stage of papillitis shown opposite p. 186 would be easily recognised by a first-time clerk in the medical wards, and might well be replaced by a diagrammatic representation of an earlier condition.

On the whole Mr. Jessop's book is distinctly the best text-book on the subject which we remember to have seen, and his achievement encourages his readers to an eager anticipation of a larger work from the same source.

ESSAYS FOR STUDENTS, by STEPHEN PAGET, F.R.C.S., Surgeon to the West London Hospital, Surgeon to the Ear and Throat Department of the Middlesex Hospital. (London: Baillière, Tindall, and Cox, 1899.)

To our versatile and valuable friends, the students, are dedicated these essays, in the hope, the preface tells us, that they who have made use of books "that are complete and necessary" may yet care to read something "that is neither one nor the other." If the meaning of this is that any of us should be advised to read what is unnecessary and incomplete, we should hesitate indeed to follow such advice in the midst of the multitudinous necessities of student preparation. However, we can with a clear conscience urge students during the period of their clinical work to peruse books such as the one before us, for they form a healthy relaxation from dry-as-dust text-books, and give (especially this one) an insight into the incidents of private practice, advice, diagnosis, and prognosis which must be often incomplete. Therefore we must disagree with Mr. Paget if he infers the non-necessity and unavoidable incompleteness of such essays as his. We do not think any student fond of bedside work, who has read books necessary and complete, will grudge the time spent in reading this one, which is "neither one nor the other."

There are four essays, one on each of the subjects of Strangulated Hernia, Cancer of the Breast, Run-over Cases, and on Aural Surgery. The method employed consists in discussing the various clinical symptoms exampled by notes, a most valuable and convenient method of note-taking in private practice, useful for our own instruction in recording our experience, and very useful for those who have the opportunity and desire to make brief communications at medical societies. To take two examples of what we mean. Mr. Paget (page 13) says, "Vomiting is a more constant sign than pain or shock; yet it may not begin until the hernia has been some time strangulated; it may stop for many hours, though the work of strangulation is going steadily on." Then follow short notes of three cases bearing on this point in which vomiting nearly ceased for almost twelve hours before it recurred. On page 55 is a frank confession of a mistake (which few surgeons of experience have not made), Case 4: "I removed the lump freely. . . . . There was no evidence of cancer, only a small abscess with very thick walls." Four cases follow to illustrate the difficulties of differential diagnosis between mammary cancer and chronic abscess, and the necessity of exploratory incision before excision. We consider reading of this kind more impressive than the re-read text-book bearing on this subject.

Dealing *seriatim* with the first essay, the subjects considered are the history of the case—despite charity and hospitals the London poor seem to be still largely untrussed; the onset of strangulation; the questions of impulse, abdominal distension, contents of sac, and the tongue—we ourselves have seen tongues of all kinds, bad in good cases, good in bad, and can quite endorse, therefore, the author's advice, "Look at the case all round." There is an interesting paragraph on strangulated hernia in infancy. In the cases there quoted the question is asked, "Might not inversion have reduced the hernia in more than one of the 'six' cases?" We doubt it. We are glad to find Mr. Paget objecting to the rigorous routine after-treatment till the bowels have moved. Cases must be taken on their merits. There are also interesting notes on the other forms of hernia, which we will leave the reader to discover for himself. Our author is a little "down" on his house surgeons.

In the essay on Cancer of the Breast we find the best examples of private practice cases; the neurotic, alcoholic, hysteroid, "insane" symptoms in connection with these diseases (pp. 74—77), the personal elements, the idea of hateful mutilation, the memory of blows, the

dislike of examination, anxiety, &c., are all what we meet with in a large practice. "One of them said her doctor had bruised the breast with his stethoscope."

That cancer of the breast is too often painless will be readily conceded,—only six weeks ago a patient walked into our consulting room with nearly a painless mass of ulcerating scirrhus. Can it be said that inflammation and injury are more than coincidences in the production of cancer of the breast? For our part we think not, and Mr. Paget's cases bear out this view. As regards operation, we are advised thoroughness, and methods which let us see what we are doing; and in this section students are talked to like adult surgeons, possibly for the best. As regards after-treatment we are here again glad to find rigour is discountenanced; we agree it adds to the troubles of mind and body, and think that tight and prolonged bandaging has no little to do with the stiff and painful shoulder-joints.

Turning to the "Run-over" cases, we have no hesitation in saying this essay is quite the best short account of these injuries that we know of. Emphasis is laid on the shock, and the possibility of simple muscular injury imitating the most serious visceral lesion,—"we cannot decipher the local injury through the general state of shock." Every practitioner must know of such anxious cases of pain, tenderness, vomiting, abdominal distension, rise of temperature occurring even after twenty hours, as are related on pages 80 and 81. The student, the cautious and non-sanguinophilous practitioner, will be pleased to find there is no necessity to do an exploratory operation in the majority of these cases, although in this matter we rather suspect Mr. Paget has tended somewhat to set up idols which he may himself demolish. There are two interesting cases of pain in the shoulder and neck, associated with injuries to the liver and spleen, which general practitioners will hail; especially interesting, also, are those of the cerebral origin of voracious hunger and thirst without glycosuria.

"The Elements of Aural Surgery" opens with a thoughtful history of the development of aural surgery from the times of Fallopius and Vesalius to the present time. In the examination of the external ear Brunton's otoscope is recommended, the use of the auscultation tube is advised, Weber's and Rinne's tests are duly considered and valued.

On page 126 will be found mention of bleeding from the external meatus not due to fractured base, the quite important fact for students to remember. The diseases of the middle ear are classified into—(1) Acute Inflammation and its consequences; (2) Chronic Catarrh and its consequences; (3) Adhesions in the Middle Ear and their consequences. For myringotomy chloroform is advised. "Not even the most liberal use of cocain will prevent it from being painful to the patient, and therefore difficult to the surgeon." Chronic catarrh receives its share of mention, but we leave its perusal as hopeless and as pessimistic as we began. The same may be said for tinnitus not due to wax, temporary inflammation or systemic disease; for them dilute hydrobromic acid is preferred to bromides, but no mention, however, is made of electrical treatment, probably advisedly; but we ourselves think it has a decided value, and so will those, we think, who may visit the Hospital's electrical department. Congenital and acquired deaf-mutism, the acquisition of lip-reading, are discussed and fairly presented to the student. The diseases of the nose and naso-pharynx are sensibly and properly valued, we learn something of acute catarrh, chronic hypertrophic and atrophic catarrh, polypi, and adenoids. In the paragraph on adenoids will be found Meyer's notes of his first case. Operation for adenoids is not considered "quite trivial," and six good rules of indications for operations are given, but to learn these, to learn the best position of the patient, the age, the kind of instrument, the anæsthetic, and much else that we have either not mentioned or merely glanced at, the student should get the book for himself, and we can assure him instruction and pleasant reading.

In such a wide range of important subjects it would be easy to criticise; we think what criticisms will come will probably be directed to the rather marked paucity of cases, to the title of the book, the absence of much precise mention of treatment (*e. g.* in chronic catarrh of the middle ear), and the use of such adjectives as "horrid" and "frightful." We think the description given (page 151) of MacEwen's supra-meatal triangle will be difficult for many to grasp, and we fail to see why in case 3, page 85, "the bubbling of air" only betokens tearing of the diaphragm or pleura. But these are small points, and the very drawing the attention to them indicates general excellence of the work.

Mr. Paget's style is lucid and conversational, and we might almost say it has a certain charm hereditary in its nature. We think the book invaluable both for its information and suggestion, and are puzzled to find so much condensed into 177 pages.

NINE MEDICAL SONGS. Words by J. BLUMFELD, G. H. RANSOME, and F. H.; the Music composed by C. N. CHADBORN. (To be obtained of the Librarian, St. George's Hospital, S.W. Price 2s. 6d., postage 3d.)

Messrs. Chadborn, Blumfeld, Ransome, and "F. H." are to be congratulated on turning out one of the smartest little books of songs seen for some time. Both the words and music are excellent, and of the nine songs there is not one which might be called even weak. Especially clever are *The Love-sick Bacillus* and *The Lament of the Large White Kidney*, while *To a Hospital Nurse* is a most dainty ditty, the music being well suited to the charming words. The book is extremely well got up, and its price ridiculously low. St. George's Hospital is to be congratulated on having given us such a production, and doubtless their Librarian (from whom copies may be obtained) will soon find it necessary to order a reprint of what, in our opinion, is the best book of medical songs ever published.

Correspondence.

To the Editor of the St. Bartholomew's Hospital Journal.

REMINISCENCES.

SIR,—I have read Sir Thomas Smith's excellent *résumé* of the early incidents of our Hospital, an institution which has never failed since October, 1832, to interest me deeply, and to afford me much pleasure. The retrospect of course brings to mind, and as one grows older and older events of one's past life become more and more vividly remembered. I may truly say that the six or seven years I passed at the Hospital as pupil (one of the last apprentices of the Hospital as described by Sir Thomas) were the happiest of my life. I had the pleasure a fortnight since of accompanying Mr. Willett in his rounds, and I wish to record my great satisfaction at the improvements in every department. I conversed with several of the students whilst waiting for my cicerone, and I must confess that in the Square and in the dissecting room their demeanour was that of gentlemen, which was not too often the case in my day. I rejoice that the many improvements, I might say comforts, in the wards and outside have had a beneficial effect upon patients and pupils. My only regret in looking back on my own career is, that I and those who were my colleagues had not the same advantages. Let the pupils of the present day accept these words as my earnest desire for their future prosperity. It appears to me that year by year the competition becomes harder and harder.

I took up my pen to relate an anecdote, and have been led by the recollection of my recent pleasant visit to scribble I fear too much for the patience of your readers. Now for the anecdote. There are few who remember Paganini, the great musician who produced from a one-stringed violin many clever musical and other sounds. He applied to the then Mr. Lawrence to be allowed admission to the operating theatre, that he might hear the agonising cry of a patient under suffering. Upon being asked whether the request should be granted, I said on one condition: "that the man gives a musical entertainment in the anatomical theatre, and pays to the funds of the Hospital five shillings per head for every one attending." I remember the shrug of the shoulder of the professor, and the rapid turning on his heels and departure. So much for philanthropy!

I am, Mr. Editor, yours faithfully, B. BARROW.

St. John's Lodge, Ryde; *December 5th*, 1898.

To the Editor of the St. Bartholomew's Hospital Journal.

THE LATE PROFESSOR KANTHACK.

SIR,—By the death of Professor Kanthack the world has lost a great worker and a brilliant teacher, one who, had he lived, would have gathered around him a school of pathologists similar to those schools associated with the names of Cohnheim and Virchow. More than this, all those who ever worked under him, or were brought into contact with him in any way, have lost a personal friend who was never too busy to give advice, who knew exactly the needs of each one, and who endeavoured to help them to the utmost extent of his power.

May I suggest, sir, that subscriptions be invited through the medium of the JOURNAL, and perhaps of other medical papers, for the purpose of founding a medal or prize with which Professor Kanthack's name may be associated, and which should be given periodically for some subject connected with pathological or bacteriological research? CHARLES POWELL WHITE.

130, Hyde Park Road, Leeds; *December 25th*, 1898.

To the Editor of the St. Bartholomew's Hospital Journal.

DEAR MR. EDITOR,—It was with the deepest regret, which will be felt alike by all of his friends and pupils in this country, that I read a telegram this morning announcing the death of Professor Kanthack.

Everybody who knew him has lost a friend, and those who were privileged to learn from him, a teacher and a master, whose methods and example they will spend their lives in following; and the more closely they do so the nearer will they come to extracting some of the most useful and valuable truths from nature. It is impossible to calculate the irreparable loss of his evenly balanced and penetrating mind to medical science.

I presume, sir, that some fitting memorial will be raised to him in the Hospital to which he was so attached, and I hope that Bart.'s men all over the world will be given an opportunity of participating and helping. Believe me, yours, &c.,

FRANK A. SMITH, M.B., B.S., Lieut. I.M.S.

Larulai, Baluchistan; *December 26th*, 1898.

Problems in Diagnosis.

(*See page* 59.)

ABSTRACT *of post-mortem notes.*—Hydatid cyst of liver; hæmorrhage into cyst; rupture of cyst.

On opening abdomen a great quantity of turbid reddish fluid escaped from it, in which floated many ruptured hydatid cysts of various sizes. Close under the abdominal wall lay the original cyst, stretching from the umbilicus upwards, and from one hypochondrium to the other. The parietal peritoneum was adherent to it at one spot on the right side, but only slightly. The cyst was covered by a false membrane for a large part of its extent. It was not adherent to any part of the alimentary canal, nor to the spleen, but the pancreas was adherent to its hinder surface. It sprang from the left lobe of the liver. The gas it contained was not derived from the stomach or intestines, for these were normal on being tested by water pressure; nor from the lung, for the cyst was not adherent to the diaphragm. The cyst wall was thin, its inner surface only slightly roughened. Its contents were a turbid mash of blood and other fluid, probably some of it purulent. The resultant colour and consistence resembled mashed strawberries and cream. Here and there varicose vessels projected into the cyst, some as large as horse-beans. The hæmorrhage was probably from one of these vessels. A great quantity of cysts of all sizes floated in the fluid. The liver, of which the right lobe only remained, with the cyst empty, weighed six pounds. The stomach was dilated, and pressed upon by the cyst. Microscopic examination of the varicose vessels showed only dilatation and thrombosis, no ingrowth of cysts.

Comment.—The interest of the case lies in the fact that the three most serious complications of hydatid cysts occurred in the same patient—suppuration, hæmorrhage, and rupture. The formation of free gas within the cyst, yielding the area of amphoric resonance, was the obscure point in diagnosis clinically. This must be a very uncommon occurrence.

Appointments.

BILL, J. F., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the Lewisham Union Infirmary.

* * *

BOUSFIELD, E. C., M.R.C.S., L.R.C.P., appointed Bacteriologist for the Parish of Camberwell.

* * *

CHASE, J., M.R.C.S., L.R.C.P., appointed Principal of the Tower House Retreat, Westgate-on-Sea.

* * *

CLARKE, F. A. H., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer at the Beech Avenue Workhouse, Nottingham.

* * *

EDDISON, F. R., M.R.C.S., L.R.C.P., appointed House Surgeon to Addenbrooke's Hospital.

* * *

FOX, E. H. B., M.R.C.S., L.R.C.P., appointed Senior House Surgeon to the Royal South Hants Infirmary.

FURNIVALL, PERCY, F.R.C.S.Eng., appointed Assistant Surgeon to the London Hospital.

* * *

GILLIES, SINCLAIR, M.D.(Lond.), M.R.C.S., L.R.C.P., appointed Assistant Physician to the Prince Alfred Hospital, Sydney, N.S.W.

* * *

GUTCH, J., M.A.(Cantab.), M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Hants County Hospital.

* * *

HAYNES, GEORGE SECRETAN, M.R.C.S., L.R.C.P., appointed House Physician to Addenbrooke's Hospital.

* * *

NAISH, A. E., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed House Physician to the Children's Hospital, Great Ormond Street.

* * *

PATERSON, H. J., M.A., M.B.(Cantab.), F.R.C.S.(Eng.), appointed Registrar to the Lock Hospital, Dean Street, Soho.

* * *

ROWLAND, S. D., M.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Assistant Bacteriologist at the Jenner Institute of Preventive Medicine.

* * *

SEVESTRE, R., M.D.(Cantab.), M.R.C.S., L.R.C.P., appointed Honorary Assistant Physician to the Leicester Infirmary.

* * *

TUNNICLIFFE, F. W., M.D., M.R.C.P., appointed an Assistant Physician for Out-patients to the Victoria Hospital for Children, Chelsea.

Examinations.

UNIVERSITY OF CAMBRIDGE.—*Third Examination: Part I.—Surgery and Midwifery.*—H. F. Bassano, S. W. Curl, W. S. Darby, J. Gutch, O. Inchley, H. R. Mayo, F. A. Rose, E. Talbot. *Part II.—Medicine, &c.*—C. H. Barnes, A. E. Carsberg, W. D. Harmer, A. C. Jordan, T. W. Letchworth, S. Pollard, E. P. Sewell, A. M. Ware.

UNIVERSITY OF LONDON.—*M.D. Examination.*—P. E. Adams, J. H. Bedman, *J. A. O. Briggs, E. G. D. Drury, J. W. Haines, A. Heath, *J. Hussey, Eldon Pratt, G. B. Price, E. J. Toye, W. B. Warde.

M.S. Examination.—J. S. Sloane.

B.S. Examination: First Division.—J. P. Maxwell (Medal). *Second Division.*—J. L. Maxwell.

* Obtained marks qualifying for Gold Medal.

Births.

FORD.—On January 6th, at 47, Ladbroke Square, W., the wife of Frank C. Ford, M.B., of a son.

MASTERMAN.—On December 8th, at 3, Newnham Terrace, Cambridge, the wife of E. W. G. Masterman, F.R.C.S., F.R.G.S., of a daughter.

MAUND.—December 25th, at Brackley House, Newmarket, the wife of John H. Maund, M.R.C.S., L.R.C.P.(Lond.), of a son.

VERRALL.—December 17th, at 97, Montpelier Road, Brighton, the wife of T. Jenner Verrall, M.R.C.S., L.R.C.P., of a son.

Marriage.

WILLIS—THRING.—On January 5th, at St. Peter's, Bournemouth, by the Rev. R. M. Willis, M.A., assisted by the Rev. R. Knightley, M.A., Cyril Hamer Willis, M.R.C.S., L.R.C.P.Lond., younger son of the late M. M. Willis, of Beckenham, Kent, to Annie Bertha, youngest daughter of the late Robert Thring, of Winchester.

ACKNOWLEDGMENTS.—*Middlesex Hospital Gazette, Nursing Record, British Dental Journal, Guy's Hospital Gazette, The Student, London Hospital Gazette, The Hospital, Medical and Surgical Review of Reviews.*